

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS5637HPC	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/10/2015
NAME OF PROVIDER OR SUPPLIER MEDICAL SERVICE OF AMERICA HOME HEALTH AND		STREET ADDRESS, CITY, STATE, ZIP CODE 2520 SAINT ROSE PKWY STE 220 HENDERSON, NV 89074		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	<p>INITIAL COMMENTS</p> <p>This statement of deficiencies was generated as a result of an attestation received 03/10/2015, in accordance with Nevada Administrative Code (NAC) Chapter 449, Provisions of Hospice Care.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>No further action is necessary. Please retain a copy of this report for your records.</p>	L 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE